Developments

Volume 25, Issue 3 | Fall 2005

Concurrent Disorders

When addiction and mental illness combine

People who have both an addiction and a mental illness are said to have a "concurrent disorder." Support for people with concurrent disorders has historically been offered in a fragmented manner. In Alberta, however, change is underway in the form of a determined and well-orchestrated effort to demystify concurrent disorders and to provide an effective protocol to prevent, identify and treat them. AADAC has led the creation of a **provincial framework** that guides development and delivery of services for people with co-occurring addiction and mental health issues.

In this issue of *Developments*, you will learn about the progress of a provincewide plan for co-operation between professionals from various disciplines, based on the documented close connection between substance abuse problems and mental illness. You will alsc gain insight into a pilot project already underway, demonstrating a collaborative approach right at the level of client service. Our opening article illustrates the complexity of the problem, and highlights the principles behind the best response we can offer, a collaborative and compassionate approach to the client. The writer brings us back to the human face of suffering, reminding us that prevention and relief of this suffering is the goal that unites the work of all the helping professionals and agencies who are AADAC's partners in alleviating the effects of concurrent disorders in Alberta.

- Deirdre Ah Shene, Editor

Getting the Picture

Helping people with concurrent addiction and mental health problems

By Jenine Safioles, AADAC Project Coordinator

"Some days the most you can do is get out of bed and get dressed. Some days getting out of bed is the goal," she said.

She was a client in a workshop I led a few years ago. She told me she had lived with depression for years before she became addicted to alcohol. She helped me realize how much a mental health issue can affect the healing from an addiction, and that it is common for people to have both.

How many other people in that workshop had a mental illness? We know that addiction and mental health issues are likely to occur together:

- A study quoted by the Canadian Mental Health Association indicated that, in Edmonton, nearly one in three adults who are mentally ill also have a substance abuse problem.
- In Canada, lifetime prevalence of substance abuse among people with a severe and persistent mental illness is about 50%.
- In the United States, research suggests that 37% of people who abuse alcohol and 53% of people who abuse other drugs have at least one serious mental illness. And 29% of all people who are diagnosed with mental illness abuse either alcohol or other drugs.

The research is consistent in indicating that people who seek help from mental health service providers have a higher rate of alcohol and other drug problems; likewise, people in treatment for substance abuse or dependence have a higher rate of mental health problems.

Getting a "picture" of co-occurring addiction and mental health problems is not easy. It is not like a puzzle, where the pieces come together neatly in a static form. Rather, it is like a kaleidoscope. Different patterns of symptoms, signs and life circumstances emerge, fade, and blend together.

Mental health and substance abuse problems are more often a combination of problems, rather than a twofold diagnosis. A person's history often contains the misuse of more than one drug, including alcohol, as well as more than one mental health diagnosis.

There are further factors that complicate the interaction between addiction and mental health issues:

- The occurrence of either addiction or mental illness increases the chance of the other one occurring.
- Addiction affects how people follow psychiatric treatment recommendations.
- Symptoms of mental illness may occur with chronic substance abuse or during withdrawal from substance use.
- Symptoms of mental illness may affect the onset, duration and effectiveness of addiction treatment.
- Mental illness has its own course of action and may flare up despite best efforts. This means that even when treatment goes well, outcomes are unpredictable.
- Disorders can develop independently at different times. A "single-diagnosis" addiction client with whom a counsellor has been working for some time may suddenly begin to show signs of mental illness.
- In those with concurrent disorders, untreated addiction problems can contribute to a recurrence or worsening of the psychiatric disorder, and untreated psychiatric problems can contribute to a relapse into the addiction.

Identifying the problem is a first step. People who have co-occurring addiction and mental health issues benefit when addictions professionals screen for the presence of mental health disorders and professionals working in the mental health field screen for problems with substance use.

People who have concurrent disorders are not a uniform group. Clinical interventions or program designs for specific groups like youth, women, seniors or Aboriginal people are not

going to be the same. Flexibility to tailor service to group and individual needs is necessary.

Other elements of effective treatment practice include working from an empowerment philosophy, offering empathy, and creating and maintaining hope. It is important to take a broad look, to learn what is happening in a person's life as well as, or as a result of, the addiction or mental health issue. Factors that lower quality of life profoundly affect efforts to be well. Poverty, marginalization and stigma, physical health problems and legal problems are examples of such factors.

Case management is crucial. This approach engages the service user as a partner in planning, co-ordinating, monitoring and evaluating service. Advocacy is also a part of case management. Case management has been described as the "core service delivery intervention for clients who have concurrent disorders."

Effective prevention and information strategies are also part of a continuum of service. At AADAC, preventing and reducing the harm associated with alcohol, other drugs and gambling is a core piece of our work. AADAC staff work from a prevention model that has a conceptual focus on risk and protective factors, resiliency, and transitional periods.

This model can be helpful to people who have mental health problems as well. The Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States notes that "though scant research has been conducted on the prevention of co-occurring substance abuse disorders and mental disorders, the limited data available suggest that since some of the risk factors for mental and substance abuse disorders may be identical (for example, low socio-economic status, family conflict, exposure to violence), programs designed to prevent one disorder may prevent or forestall development of the other."

How do we best help people who have co-occurring substance misuse and mental health problems? Research suggests that we do have a good picture of what works:

- Provide services across the spectrum of information, prevention and treatment, including harm reduction services.
- Identify people who have co-occurring disorders; welcome them and prepare for them.
- Work with them from an empowerment philosophy; offer empathy and build hope.
- Help them see and build on their strengths and existing supports including family and self-help or mutual aid groups.
- Tailor service as much as possible to individual treatment needs (for example, readiness to change or age/developmental stage).

All of these strategies are most effective when the people providing the services create strong links with each other, and work together toward the common goal of helping people with concurrent disorders.

FURTHER READING

This article draws on information from the resources below:

Alberta Alcohol and Drug Abuse Commission. (2005). *Prevention makes a difference: A qualitative study of prevention initiatives*. Edmonton, AB: Author.

Canadian Mental Health Association, Ontario Division. (1997). *Concurrent disorders: Policy consultation document*. Toronto, ON: Author.

D. Daley & B. Moss. (2002). *Dual disorders: Counselling clients with chemical dependency and mental illness*. Center City, MN: Hazelden.

Health Canada. (2002). *Best practices: Concurrent mental health and substance use disorders*. Ottawa, ON: Author.

K. Mueser, D. Noordsy, R. Drake, & L. Fox. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: The Guilford Press.

National Alliance for the Mentally Ill. (2004). *Dual diagnosis and integrated treatment of mental illness and substance abuse disorder* [Electronic version]. Available from http://www.helpguide.org/mental/dual_diagnosis.htm

B. Rush. (2004). Best practices guidelines for the treatment and support of people with concurrent substance use and mental disorders. *Visions, 2*(1), 7–10.

Substance Abuse and Mental Health Services Administration. (2002). *Report to congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders*. [Electronic version]. Available from www.samhsa.gov

The Alberta Story

The complex needs of people with concurrent disorders must be addressed from both a mental health and an addictions perspective. With a few notable exceptions, these two services have historically been delivered in a fragmented manner in Alberta. The result has been frustration for service providers and less than optimal services for clients. In other words, clinicians—particularly those at the field level—have known for some time that we need a new approach.

Collaborating for Change

In June 2004, the Provincial Mental Health Plan for Alberta specified that AADAC would lead the development of a new provincial strategy. Best-practice literature supported a collaborative framework that involved all partners at all levels: community, regional, provincial and national. This approach was also strongly advocated by front-line workers in both the mental health and addiction fields.

In addition to reviewing international approaches, best-practice research and expert opinions, AADAC consulted with health regions, physicians, the Alberta Mental Health Board and other key stakeholders. Health region representatives, physicians and AADAC staff came together in regional forums to provide ideas about what to include in a provincial strategy, as well as areas where immediate actions could improve service. Clients and advocates from across the province were also interviewed about their experiences and perspectives. All of this consultation told us what we had already hoped: that people want to work together and are looking forward to a strategy of ongoing collaboration. The resulting plan is a made-for-Alberta framework that is research- and experience-based and is in keeping with Alberta's human service system.

A Model of Shared Caring

The new provincial framework (outlined in the document *Building Capacity: A Framework for Serving Albertans Affected by Addiction and Mental Health Issues*) is built around a series of guiding principles: that services should be accepting, accessible, accountable, capacity-focused, comprehensive, evidence-based, minimally intrusive, and sustainable. The approach is one in which addiction and mental health service providers across the province would adopt a "shared care responsibility" for providing flexible services focused on the individual needs of clients with concurrent disorders. In this framework, counsellors and therapists contribute their collective skills and energies to client screening, assessment, treatment and follow-up, as well as information and prevention approaches.

Of course, this doesn't mean that every client needs the direct involvement of a mental health clinician and an addictions clinician. Rather, every service provider would have familiarity with concurrent disorders and be prepared to deal with or refer those suffering from concurrent disorders. Through this collaborative approach, clients will receive service in the best way possible, sometimes through one agency assuming a primary role with support from another service, and sometimes through a sharing of primary responsibilities. This is a model of shared caring.

The approach is also person-centred—the client's unique set of personal strengths and external supports (such as family members and community agencies) is acknowledged and seen as vital to the therapeutic process. Mental health and addictions professionals then help the client to build on those strengths, and use them to best advantage.

The framework identifies four "domains of care" based on the level of the client's presenting problems and need for mental health and addiction-related care. Domain I, for example, seeks to meet the needs of those whose presenting problems appear so mild that they would not normally invite attention from the formal human service system. These Albertans are best served by information, prevention, and early intervention strategies. Severity of problems increases through the second and third domains (respectively, more severe mental health problems with milder addiction problems; and milder mental health problems with more severe addiction problems) to the fourth domain, which is designed to meet the needs of those with severe addiction and mental health problems. The framework document helps professionals in addiction and mental health to ensure that people in all four domains are served, to decide who is responsible for service and to what degree, and to outline an appropriate response to an assessed set of needs.

To determine the domain in which a person's needs may best be met, the addictions counsellor or mental health clinician would begin with universal screening and, when required, in-depth assessment to define the nature and scope of the problem. In each domain, a full range of service options is possible, and specific treatments are based on the clinician's assessment and the client's goals for treatment.

This collaborative model has a number of benefits. It builds on the unique expertise of providers in serving different client groups. It encourages universal screening and comprehensive assessment. It promotes dynamic treatment planning to ensure that both the addiction and the mental health problems are treated appropriately. The result: service that is effective, seamless and transparent to clients and their significant others. The framework is also adaptable to the particular strengths and capacities of individual communities, making it more likely to be meaningful and successful.

Making the Framework a Reality

The framework identifies 17 building blocks for service delivery, inspired by the principles mentioned above. Each of these is specific and tangible and will move framework participants forward in creating an effective system of shared care for people with concurrent disorders. The building blocks include, for example, articulating the roles of the various service providers, refining screening and assessment, and identifying required staff and program competencies.

With the framework approved by the members of AADAC's board, implementation is now underway provincially and locally. AADAC staff and most health regions have identified plans for working collaboratively in the short run. In some health regions, shared care is already a fact. The collaborative spirit that is found throughout the province reminds us that this new approach already has what it needs most to succeed: the passion and commitment of all the actors involved.

Building a Shared Language

Capital Health and AADAC co-operate for better treatment of concurrent disorders

By Roszan Holmen

Within the Capital Health region, the staff at AADAC and at Capital Health's Regional Mental Health Program (RMHP) have gotten to know each other a bit better over the past few months. Through ongoing weekly site visits, job shadowing and program orientations, the two groups of service providers are putting faces to names, and strengthening pre-existing relationships.

Starting in March 2005, these team-building exercises marked the first steps in a new Capital Health/AADAC demonstration project.

As the first of its kind in the province, the project is modelled after a theoretical framework developed by AADAC in collaboration with Alberta's health regions, as outlined in the document *Building Capacity: A Framework for Serving Albertans Affected by Addiction and Mental Health Issues*. The framework outlines a collaborative strategy between AADAC and Capital Health staff, designed to improve service to Albertans affected by both addiction and mental health issues.

Putting theory into action, the Edmonton-area demonstration project is "something for people to sink their teeth into," says Allan Aubry, senior manager of AADAC Adult Counselling and Prevention Services in Edmonton.

"We decided a good starting point would be for our staff, our counsellors, our therapists, to get a better sense for who each other was," continues Aubry. "That's paramount if we're going to be working collaboratively." As both organizations have gone through a number of significant changes over the past few years, staff members were re-educated on the philosophies and range of services offered by each.

The partnership is not entirely new. Informally, the two organizations have co-facilitated numerous concurrent disorder programs extending as far back as 10 years. The demonstration project "builds in a logical and natural progression from some of those previous success stories," says June Clark, regional manager of Urban Community Clinics for Capital Health. "The previous work has been less formal and less structured, and probably pretty low-key, but there's been a definite thread that we could build upon."

This history of working together is one reason for the Capital Health region's participation in demonstrating how the *Building Capacity* framework can be implemented successfully.

Early this spring, some AADAC counsellors at various pilot sites were trained in using a new assessment tool: the Concurrent Disorder Assessment, designed to screen clients for both addiction and mental health problems.

Clark, whose staff members were impressed with the assessment tool, expressed interest in increasing their ability to screen for concurrent disorders. As a result, 140 service providers have been trained to use the Alcohol Dependence Scale (ADS) and the Drug Abuse Screening Test (DAST). These screening tools, says Clark, "will allow the two staffing groups to begin to have a shared language."

Trained staff at Capital Health and AADAC now have clear criteria to identify signs and symptoms of addiction and of mental health problems. Having a shared vocabulary to communicate their concerns will enhance everyone's ability to work collaboratively toward a solution. The result is more comprehensive treatment, which acknowledges concurrent disorders as being interrelated and requiring a collaborative, integrated approach.

For some staff members, this presents a significant change in thinking about and working with concurrent disorders. For many years the recommended practice was to treat concurrent disorders separately, with the most pressing need being addressed first. Capital Health intake therapist Wendy Lafleur confirms that "there are still therapists who feel that therapy won't be successful until the addiction is taken care of."

For the most part, however, service providers are enthusiastic about the collaboration. For AADAC counsellor Riina Shymko, the opportunity to job-

shadow and consult with Capital Health has been very positive and helpful, particularly when she has specific questions regarding the medication clients are taking. Lafleur agrees, noting that AADAC staff are very interested in learning about the different medications clients may be prescribed, their side effects, and what to expect and monitor.

Lafleur also speaks to Capital Health staff gaining knowledge and skills to help deal with their clients' addictions: "When the two services work together, we are able to address each issue as it comes up in the session. For instance, when a client is describing his mood and the effect smoking drugs seems to have on it, the AADAC counsellor can take the lead in the session and introduce ways to examine or change this behaviour." In turn, the Capital Health therapist's skills and abilities are further developed and their capacity to deal with addiction issues presented by their clients is enhanced.

Similarly, when dealing with clients who exhibit disorders outside their expertise, AADAC counsellors now have the option to consult with their counterparts in Capital Health about best practices. In more serious cases, the counsellor can invite the therapist to sit in on the session with the client, giving the counsellor the opportunity to watch and learn first-hand how the Capital Health service provider approaches issues and concerns.

"A big part of the work is to increase the dual capabilities of staff members," says Aubry. "Just because your expertise is as an addictions counsellor doesn't mean you can't support someone who is experiencing depression." This is important, he stresses, because "there's nothing more frustrating for a service provider [than] to think 'I'm just spinning my wheels; I'm not helping this person because of other issues.'"

The collaboration also prevents clients from being passed back and forth between organizations. Now, the first person with whom the client establishes a relationship will continue to be primarily responsible for her or his treatment. According to Aubry, "the number one most important factor [in successful outcomes] is client connectedness and confidence within the counselling relationship...we try to limit the number of service providers involved as much as possible."

Later, if it becomes apparent the client needs specialist care beyond the capability of the first provider, that transfer will be facilitated. For clients with limited resources, this facilitation makes all the difference. Having already disclosed personal information to the first service provider, they are unlikely to follow through with treatment if they have to start from scratch with a new service provider. Now, clients can sign a shared release of confidential information and be reassured that there is someone waiting for them at the partner organization who already knows their name and understands their needs. Instead of "sending [clients] out into the wild blue yonder," Lafleur has a liaison at AADAC who can help direct her clients to the right AADAC service group.

Clark points out that despite the challenges ahead, "we've moved incredibly quickly, considering it was only in February that we had our first conversation about what we might be doing." She also stresses this progress has been achieved without new funding. "I think an important lesson of the demonstration project is that you can improve services without additional dollars."

Although it's too early to talk about client outcome, the program is already a success according to Aubry. "We have the agreement of the clients, the administration and the service providers that it is a valuable and effective product."

The Back Page

JOIN THE AADAC TEAM!

Ninety per cent of AADAC employees are satisfied in their work with AADAC. Eighty percent feel valued as employees. Ninety-two per cent feel enthusiastic about the work they do.

Want to be part of this exceptional work force? Check out the current career opportunities at AADAC.

AADAC WEBSITE SURVEY

AADAC is looking for a few good *Developments* readers to help us improve our websites.

Please take a few minutes to complete our online survey. The results of this survey will be used to improve the way we use AADAC's websites to assist Albertans in achieving freedom from the harmful effects of alcohol, other drugs and gambling. Your input will help us to understand your expectations and information needs, and to identify potential enhancements to AADAC websites.

Your answers and comments will be completely anonymous, and all data collected will strictly adhere to AADAC's privacy policy.

CLICK TO QUIT AT ALBERTAQUITS.CA

Albertans who want to quit smoking now have a personal, private, powerful way to get help.

Officially launched October 31, 2005, **albertaquits.ca** is a free, web-based interactive program managed by The Lung Association, funded by AADAC and supported by the Canadian Cancer Society.

The website offers personalized quit plans, expert advice and support, extensive information resources, and a thriving virtual community of supportive people who are helping each other "click to quit."

For more information or to sign up for your free membership, please visit www.albertaquits.ca

CONFERENCE ON FASD

Navigating the Rapids: Doing What Works in Practice
Second National Biennial Conference on Late Adolescents and Adults with Fetal Alcohol Spectrum Disorder
May 4 to 6, 2006

This conference will focus on improving quality of life for adults affected by FASD. It will feature innovative approaches used by practitioners in a variety of settings while working directly with affected individuals, their families and their support systems. "Navigating the Rapids" will provide participants with the tools necessary for designing optimal environments for the social, emotional, spiritual, and physical well-being of individuals with FASD.

Navigating the Rapids will be held at The Coast Hotel and Conference Centre in Vancouver, British Columbia.

www.interprofessional.ubc.ca

For more information, contact Leanne Fuhr at ipinfo@interchange.ubc.ca or by phone at 604-822-2801.

Copyright & Disclaimer Statement
Privacy Statement

AADAC
ALBERTA ALCOHOL AND DRUG ABUSE COMMISSION

Suite 200, 10909 Jasper Avenue
Edmonton, Alberta, Canada T5J 3M9

ISSN: 1712-1736